Appendix 3
HCFA 1500 Claim Form Instructions for Nursing Home Services

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Medicaid recipients receive an identification card when initially enrolled in Wisconsin Medicaid and at the beginning of each following month. Providers should always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Element 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "D" (Durable Medical Equipment or Disposable Medical Supplies) or "T" (Therapy services) for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

Element 1a - Insured's ID Number
Enter the recipient's 10-digit identification number as found on the current identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial as it appears on the current identification card.

NOTE: A provider may submit claims for an infant if the infant is ten days old or less on the date of service and the mother of the infant is a Medicaid recipient. To bill for an infant using the mother's identification number, enter the mother's last name followed by "Newborn" in element 2. Enter the *infant's* date of birth in element 3. In element 4 enter the mother's name followed by "Mom" in parentheses. Finally, in element 1A enter the mother's ten-digit identification number.

Element 3 - Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the identification card. Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient Relationship to Insured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
Health insurance (commercial insurance coverage) must be billed prior to billing Wisconsin Medicaid, unless the service does not require health insurance billing according to Appendix 18a of Part A of the provider handbook.

- When the provider has billed the health insurance because the "Other Coverage" of the recipient's identification card is blank, the service does not require health insurance billing according to Appendix 18a of Part A of the provider handbook, or the recipient's identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires health insurance billing according to Appendix 18a of Part A of the provider handbook, one of the following codes *must* be indicated in the *first* box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by the health insurance. The amount paid by the health insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by the health insurance following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. DO NOT use this code unless the claim in question was actually billed to and denied by the health insurer.
OI-Y	YES, the card indicates other coverage but it was not billed for reasons including, but not limited to: ◆ recipient denies coverage or will not cooperate; ◆ the provider knows the service in question is noncovered by the carrier; ◆ health insurance failed to respond to initial and follow-up claim; or ◆ benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by Wisconsin Medicaid except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill Wisconsin Medicaid for services which are included in the capitation payment.

Element 10 - Is Patient's Condition Related to (not required)

Element 11 - Insured's Policy, Group or FECA Number

This *first* box of this element is used by Wisconsin Medicaid for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to Wisconsin Medicaid. When the recipient's identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes *must* be indicated. The description is not required.

Code	Description
M-1	**Medicare benefits exhausted**. This code applies when Medicare denied the claim because the recipient's lifetime benefit, spell of illness or yearly allotment of available benefits is exhausted.
M-5	**Provider not Medicare certified**. This code applies when the provider is not required by Wisconsin Medicaid to be Medicare Part A or Part B certified, has chosen not to be Medicare Part A or Part B certified or *cannot* be Medicare Part A or Part B certified.
M-6	**Recipient not Medicare eligible**. This code applies when Medicare denied the claim because there is no record of the recipient's eligibility.
M-7	**Medicare disallowed or denied payment**. This code applies when Medicare actually denies the claim for reasons given on the Medicare remittance advice.
M-8	**Noncovered Medicare service**. This code applies when Medicare was not billed because Medicare does not cover the service at this time. A list of noncovered Medicare services is in Appendix 16 of Part A, the all-provider handbook. Nursing homes must use M-8 for Medicare-eligible recipients who are hospitalized and do not wish to return to a Medicare-covered bed.

If Medicare is not billed because the recipient's identification card indicates no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefit (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the provider handbook for further information regarding the submission of claims for dual entitlees.

Elements 12 and 13 - Authorized Person's Signature
(Not required since the provider automatically accepts assignment through certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient Has Had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source
When required, enter the referring or prescribing physician's name.

Element 17a - I.D. Number of Referring Physician
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the Medicaid provider number or license number of the referring provider.

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use
If an unlisted procedure code is billed, providers may describe the procedure in this element. If there is not enough space for the description, or if multiple unlisted procedure codes are billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

Element 20 - Outside Lab
If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab. Otherwise, this element is not required.

Element 21 - Diagnosis or Nature of Illness or Injury
The International Classification of Disease (ICD) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

Element 22 - Medicaid Resubmission (not required)

Element 23 - Prior Authorization
Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

Element 24a - Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge *per detail line* in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same emergency indicator.

Element 24b - Place of Service
Enter the appropriate Medicaid *single-digit* place of service code for each service.

Code	Description
7	Nursing Home
8	Skilled Nursing Facility

Element 24c - Type of Service Code
Enter the appropriate single-digit type of service code.

Element 24d - Procedures, Services, or Supplies
Enter the appropriate HCPCS procedure code and, if applicable, a two-character modifier under the "Modifier" column.

Element 24e - Diagnosis Code
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

Element 24f - Charges
Enter the total charge for each line.

Element 24g - Days or Units
Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed.

Element 24h - EPSDT/Family Planning (not required)

Element 24i - EMG
Enter an "E" for *each* procedure performed as an emergency, regardless of the place of service.

Element 24j - COB (not required)

Element 24k - Reserved for Local Use
Enter the eight-digit provider number of the performing provider *for each procedure*, if it is different that the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the provider handbook for information on recipient spenddown.

Element 25 - Federal Tax ID Number (not required)

Element 26 - Patient's Account No.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the fiscal agent Remittance and Status Report.

Element 27 - Accept Assignment
(Not required, provider automatically accepts assignment through Wisconsin Medicaid certification.)

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount Paid
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.) Do not enter dollar amounts paid by Medicare.

Element 30 - Balance Due
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier
The provider of the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered

If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit provider number.

Element 33 - Physician's, Supplier's Billing Name, Address, Zip Code and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit provider number.